MARYLAND
DUALS CARE DELIVERY WORKGROUP

MAY 2, 2016 | 1:00-4:00 PM

AGENDA

- Welcome and Introductions
- Recap of the Previous Meeting
- Guiding Principles
- Stakeholder Input on the Guiding Principles
- Refined Straw Models Presentation and Discussion
- Discussion Questions
- Wrap-up, Takeaways and Next Steps
- Public Comment

RECAP

- At Duals Workgroup meeting #2, we shared 3 models for duals care delivery in Maryland: Managed FFS, Duals ACO, and Capitated Models.
- In April, we collected feedback from stakeholders and Workgroup members regarding these models, as well as the guiding principles at the foundation of any potential duals care delivery model
- We met with a sub-workgroup of stakeholders to discuss and develop a common definition of "care coordination" to use when developing a duals model
- DHMH and consultants met with CMS to preview the potential models
- DHMH and consultants continued to work on and refine the three models based on stakeholder and CMS feedback

GUIDING PRINCIPLES

In designing new care delivery models for dual eligibles …

For Beneficiaries

- Reach for whole-person care integration
  - Physical/Acute
  - Behavioral
  - LTSS
  - Social
- Follow a person-centered care model
- Aim for improved
  - Patient experience
  - Health outcomes
  - Quality of life
  - Access to care

For Providers

- Promote value-based payment to reward providers who help reach program goals
- Support providers via
  - Health information exchange
  - Analytics tools
  - Administrative simplicity
- Enable physicians to qualify for APMs under MACRA

For the State

- Address total cost of care for both Medicaid and Medicare
- Make the program interoperable with the All-Payer Model

Cross Cutting

- Promote utilization of community-based resources

STAKEHOLDER INPUT ON GUIDING PRINCIPLES

Six (6) responses were received regarding the guiding principles/model tool. Responses varied; however, there was consensus that any model will need to emphasize care coordination and person centered-care. Some highlights:

- A managed FFS model "*has the best ability to reach for whole-person care to integrate physical, mental, and social components of health…"* and "*gives beneficiaries the most flexibility in provider choice while still providing the benefits of a medical home and care coordination."*
  - Financial risk at the provider level could include a percent reward based on quality outcomes if savings are achieved. The risk sharing could also include negative risk.
- *"A specialty ACO could address the unique needs of populations such as those with serious mental illness and substance use disorders… The ACO model allows for continuation of existing relationships between community providers and enrollees."*
- *"Capitated Managed Care Organizations have proven experience serving this population through whole person care models (including FIDE D-SNPs, MLTSS, and MMP demonstrations), delivering fully integrated benefits that span physical, behavioral, social, and long term care services and supports."*

DEFINING CARE COORDINATION

Preface

In all potential models, we expect beneficiaries to experience good care coordination.

Not all workgroup members shared a common understanding of the term.

An *ad hoc* subgroup convened to discuss the meaning of care coordination so as to reach a commonly accepted definition, tailored to dual eligibles.

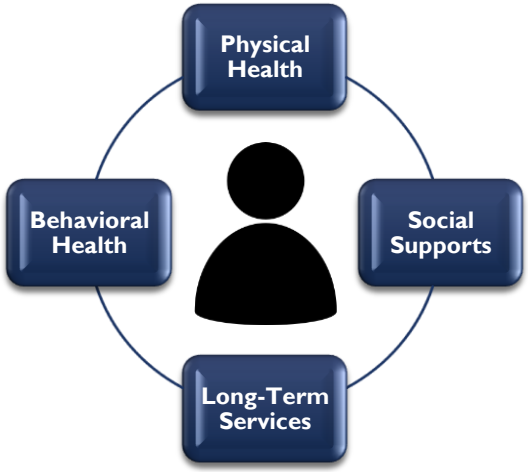
Consensus emerged around an adaptation of the definition put forth by the federal Agency for Healthcare Research and Quality (AHRQ).

Of note, the subgroup emphasized the importance of coordinating care across the domains of physical health, behavioral health, long-term care, and social supports.

CARE COORDINATION & CARE MANAGEMENT

Care Coordination – Includes sub-committee recommendations

- Care coordination is the strategic, tactical, and operational organization of beneficiaries' and individuals' care activities; this includes family caregivers. Coordination will address the social determinants of health and facilitate the delivery of appropriate health care, long-term care, and supportive social services.
- Driven by a comprehensive person-centered plan – for those who would likely benefit – care coordination services are intended to balance individual/family, community and cultural preferences and needs within fiscal resource limits.
- Coordination, especially during transitions, often entails the deployment of interdisciplinary teams that include the individual, family caregivers, and health professionals. This team focus during deployment facilitates care management (see next page).
- Coordination is managed by the exchange of interoperable information among participant teams and families using evidence-based methods and promising practices achieving maximal expertise at the point of service.



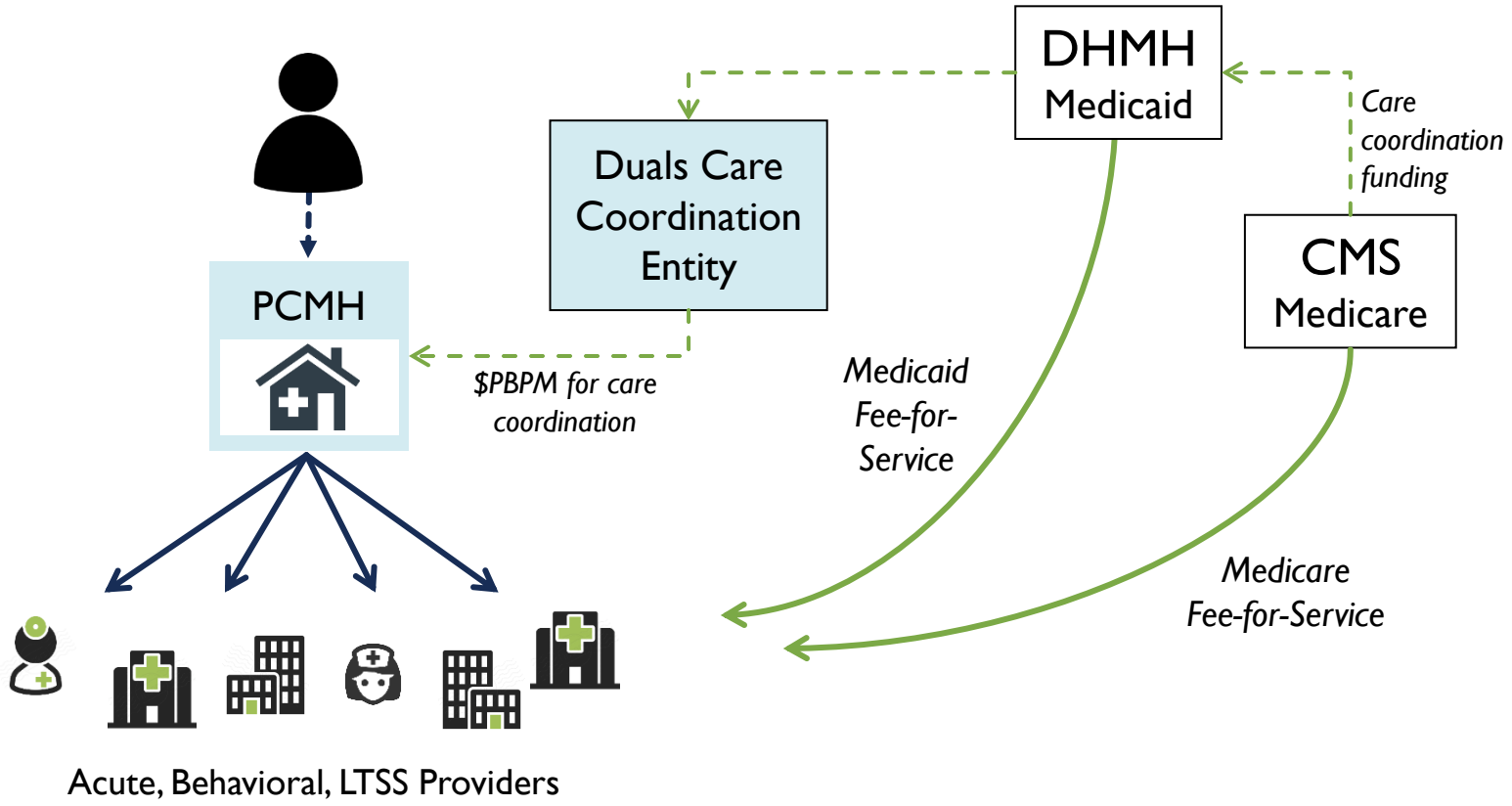
CARE COORDINATION & CARE MANAGEMENT

Care Management

Care management is a process designed to assist patients and their support systems in managing their medical/social/behavioral health conditions more efficiently and effectively and as possible achieve self-direction and self-management. Case management and disease management are included in this definition.

- Case management - A collaborative process of assessment, planning, facilitation, and advocacy for options and services to meet an individual's health needs through communication and available resources to promote quality cost-effective outcomes. (Source: Case Management Society of America)
- Disease management - A system of coordinated health care interventions and communications for populations with conditions in which patient self-care efforts are significant. Disease management supports the physician/practitioner - patient relationship and plan of care, emphasizes prevention of exacerbations and complications utilizing evidence-based practice guidelines and patient empowerment strategies, and evaluates clinical, humanistic, and economic outcomes on an ongoing basis with the goal of improving overall health.
  (Source: Disease Management Association of America)

MANAGED FEE-FOR-SERVICE FOR DUALS



♦ PCMH = Patient-Centered Medical Home ♦ LTSS = Long-Term Services & Supports ♦ PBPM = Per Beneficiary Per Month

MANAGED FEE-FOR-SERVICE FOR DUALS

Beneficiaries to Be Covered by MFFS-D

- Full-benefit duals not with intellectual/developmental disabilities (I/DD)
- Those above not included in MFFS-D:
  - Medicare Advantage (MA) enrollees
  - PACE enrollees
  - Dual eligibles already aligned with pre-existing Medicare ACOs
    - Beneficiaries who disenroll from MA or PACE or who opt out of Medicare ACOs will be taken up by MFFS-D

♦ PACE = Program of All-inclusive Care for Elderly ♦ ACO = Accountable Care Organization

MANAGED FEE-FOR-SERVICE FOR DUALS

Patient-Centered Medical Home (PCMH)

- Entities eligible to be PCMH may include:
  - Primary care practices capable of addressing needs of duals
  - Practices linked to LTSS providers for beneficiaries in LTSS (NF or HCBS)
  - Specialty providers for beneficiaries having dominant chronic condition, such as mental illness
- PCMH assumes responsibility for coordinating all beneficiary care
  - Whole-person perspective – preventive care, chronic care, acute care, etc.
  - Physician works with an Inter-disciplinary Care Team (ICT) to direct care and support the needs of beneficiary
  - Care is integrated across health systems and providers via data exchanges
  - PCMH is accountable for quality performance

♦ NF = Nursing Facility ♦ HCBS = Home- and Community-Based Services ♦ ICT = Interdisciplinary Care Team

MANAGED FEE-FOR-SERVICE FOR DUALS

Beneficiary Linkage to PCMH

- Dual eligible beneficiaries are attributed to PCMHs:
  - First, beneficiary offered a choice of PCMH
    - Counseled toward regular primary care provider or a suitable and accessible PCMH
  - Those who don't choose are passively assigned to a PCMH using historical data
    - Beneficiaries without historical provider relationships assigned to appropriate PCMH based on location, other criteria for suitability
- Beneficiary is not locked into using PCMH
  - Care coordination entity (CCE) may engage to steer beneficiary toward PCMH, or redirect to a PCMH more suitable to beneficiary's needs

MANAGED FEE-FOR-SERVICE FOR DUALS

Care Coordination Entity (CCE)

CCE contracted by DHMH, serves as care coordination hub

- CCE contractor could be …
  - Organization formed by providers in communities (except PCMH providers)
  - Health plan furnishing only care coordination services
  - Private firm offering capabilities required of CCE
- CCE scope of work entails …
  - Analysis of data on duals to identify greatest opportunities for improvements in care quality and cost savings
  - Facilitation of CRISP tools
  - Aid to PCMH and directly to beneficiaries in navigating all health services
  - Assurance that PCMH implements chronic care management
  - Appraisal of PCMH performance; technical assistance to improve effectiveness

MANAGED FEE-FOR-SERVICE FOR DUALS

Care Coordination Entity (CCE) - continued

- CCE scope of work may also encompass utilization management
  - Intensive case management for duals deemed high need or at risk of high cost
  - Pre-authorization of services judged overused or high cost and uncertain efficacy

MANAGED FEE-FOR-SERVICE FOR DUALS

Payment for Care Coordination

- All provider payment for care is regular Medicare/Medicaid fee-for-service
- Care coordination funds for CCE and PCMH sourced from CMS & DHMH
  - Agencies allocate funds out of anticipated health cost savings
  - CMS adds chronic care management (CCM) fee to fund for affected duals*
    - Providers would agree to forgo claiming CCM fee
- CCE receives budget allocation from DHMH
- PCMH receives a care coordination payment per beneficiary per month
  - Amount PBPM to be stratified by beneficiary health status category

CMS has just announced an initiative called Comprehensive Primary Care Plus (CPC+) that has some similar features and is intended to be multi-payer. We will assess whether the concept proposed here can/should be built to match CPC+.

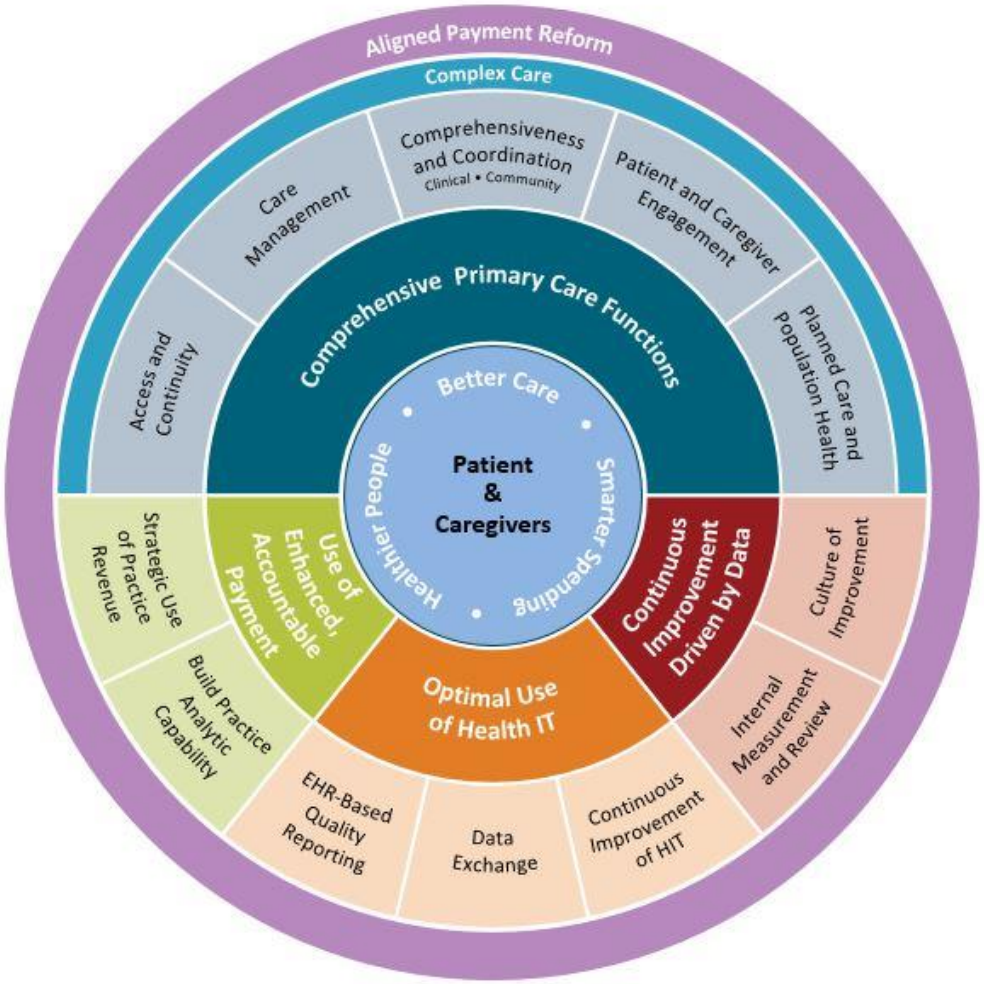
*Chronic Care Management: "At least 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month." CMS code 99490 – paid at $42/month

SIDEBAR: COMPREHENSIVE PRIMARY CARE PLUS

Advanced PCMH model: aims to strengthen primary care through a regionally-based multi-payer payment reform and care delivery transformation

- Give practices greater financial resources and flexibility to make appropriate investments to improve quality and efficiency of care, and reduce unnecessary utilization
- Actionable patient-level cost and utilization data feedback, to guide practice decision making

CMS seeks payer proposals to partner with Medicare in CPC+ (due June 1, 2016)



Source: CMS webinar presentations and CPC+ webpage: https://innovation.cms.gov/initiatives/Comprehensive-Primary-Care-Plus

SIDEBAR: COMPREHENSIVE PRIMARY CARE PLUS

Practice Functions	Examples for Track 1	Additional examples for Track 2
Access and Continuity	24/7 patient access Assigned care teams	E-visits Expanded office hours
Care Management	Risk stratify patient population Short- and long-term care management	Care plans for high-risk chronic disease patients
Comprehensiveness and Coordination	Identify high volume/cost specialists serving population Follow-up on patient hospitalizations	Behavioral health integration Psychosocial needs assessment and inventory resources and supports
Patient and Caregiver Engagement	Convene a Patient and Family Advisory Council	Support patients' self-management of high-risk conditions
Planned Care and Population Health	Analysis of payer reports to inform improvement strategy	At least weekly care team review of all population health data

SIDEBAR: COMPREHENSIVE PRIMARY CARE PLUS

- Payment for care is FFS in Track 1, hybrid of FFS and per capita in Track 2
  - Track 2 practices will receive "Comprehensive Primary Care Payments (CPCP)" – a hybrid of Medicare FFS and a percentage of their expected Evaluation & Management (E&M) reimbursements upfront in the form of a CPCP. Practices will receive a commensurate reduction in E&M FFS payments for a percentage of claims.
- In addition to payment for care:
  - Care management fee
  - Performance incentive: Incentive payments are prepaid at beginning of a performance year, but practices may only keep these funds if quality and utilization performance thresholds are met.

	Care Management Fee (PBPM)	Performance-Based Incentive Payment	Underlying Payment Structure
Track 1	$15 average	$2.50 opportunity	Standard FFS
Track 2	$28 average; including $100 to support patients with complex needs	$4.00 opportunity	Reduced FFS with prospective "Comprehensive Primary Care Payment" (CPCP)

MANAGED FEE-FOR-SERVICE FOR DUALS

Rewards for Positive Outcomes

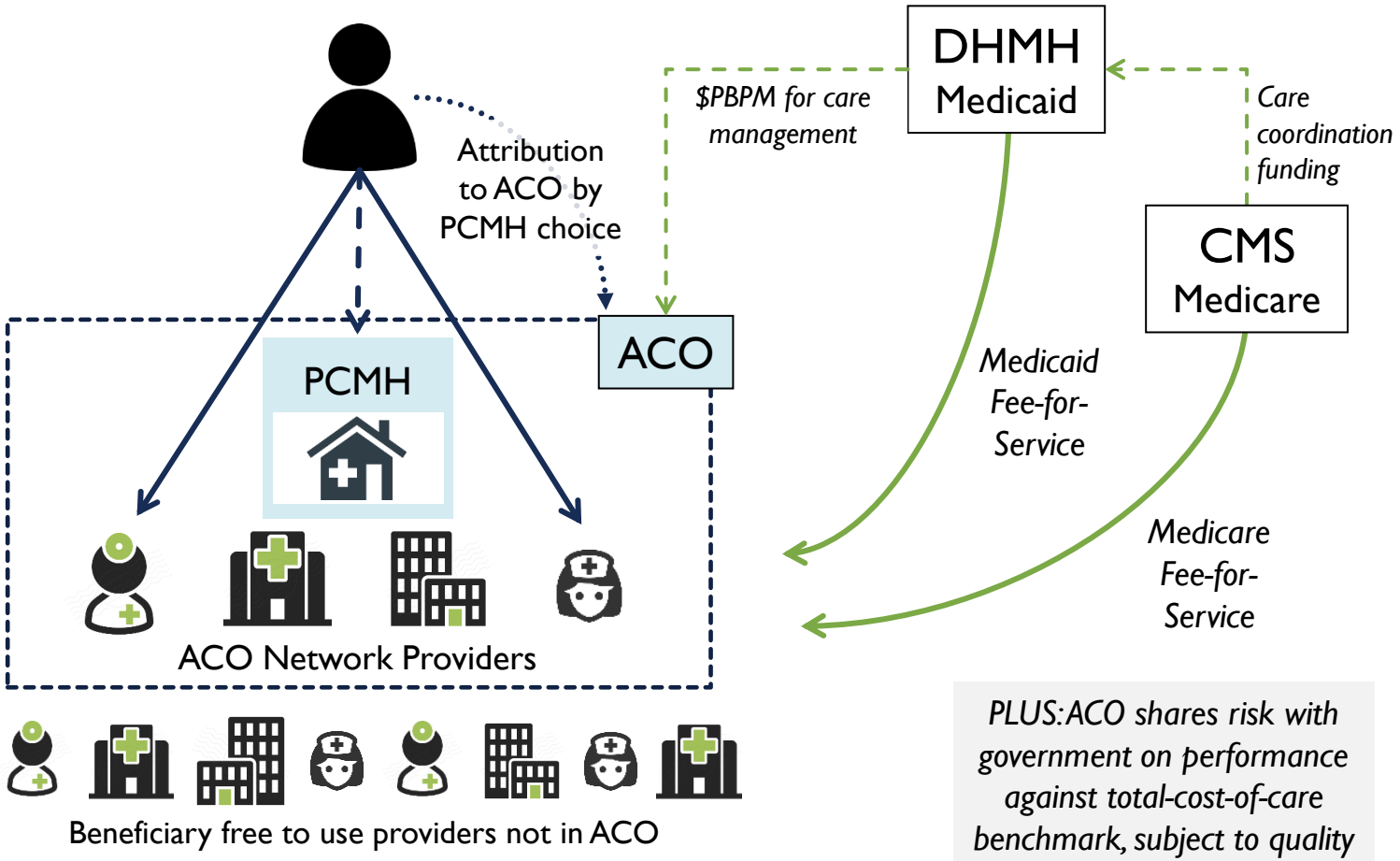
- CMS & DHMH set a combined Medicare-Medicaid total cost of care (TCOC) target, against which CCE/PCMH performance is measured
  - TCOC is government cost of all Medicare and Medicaid services used by duals
  - Target is computed as expected per capita cost,
    … adjusted for health status/risk of covered individuals
    … summed across the entire population
- After paying all claims, agencies calculate end-of-year surplus/deficit vs. TCOC target
- If there is a surplus …
  - CCE awarded bonus for achieving surplus
  - PCMHs shown to have contributed to surplus may share in bonus awards

DUALS ACO

Accountable Care Organizations - Background

- ACOs are groups of doctors, hospitals, and other health care providers – *and, for dual eligibles, LTSS providers* – who join together voluntarily to give coordinated high quality care to their aligned populations
- ACOs generally differ from managed care in 2 key ways:
  - Beneficiaries do not formally enroll and are not locked into using ACO providers
  - Payment is usually fee-for-service, not capitation, and risks are limited
- Since 2012, Medicare has run the Medicare Shared Saving Program
  - 433 ACOs participate in MSSP nationally, of which 22 are based in Maryland
  - CMS reports 17,400 full duals in Maryland are attributed to 33 ACOs (includes ACOs based in other states, having a Maryland presence)
- Some states have introduced ACO-like programs in Medicaid
  - May be more like MFFS or capitated plans, or embed ACOs inside MCOs
  - No evidence of other states having implemented ACOs for duals

DUALS ACO



PLUS:ACO shares risk with government on performance against total-cost-of-care benchmark, subject to quality

DUALS ACO

Qualifications of Duals ACOs

- The Duals ACO (D-ACO) is a provider-sponsored network that covers part or all of Maryland
  - D-ACOs may define own service areas as long as those areas are contiguous and non-discriminatory
  - More than one D-ACO is allowed in any given area
- Sponsors may include any type of provider serving Medicare or Medicaid beneficiaries or a combination thereof
  - Sponsors must demonstrate capability to provide a network for all Medicare Part A or B and Medicaid services (no Medicare Part D – outpatient pharmacy)
- Pre-existing Medicare ACOs may elect to become D-ACOs
  - Augment capabilities, such as by adding LTSS providers to networks
  - Must apply to DHMH and receive approval for D-ACO designation
    - Secondary review by CMS
  - An MSSP ACO's participation as a D-ACO does not alter the MSSP-side model, but requirements on the D-ACO-side will differ from MSSP

DUALS ACO

Beneficiaries to Be Covered By D-ACOs

- Full-benefit duals not with intellectual/developmental disabilities (I/DD)
- Those above not included in D-ACO:
  - Medicare Advantage (MA) enrollees
  - PACE enrollees
  - Dual eligibles residing in areas of Maryland not served by D-ACOs
  - Dual eligibles already in pre-existing Medicare ACOs that do not attain D-ACO designation

DUALS ACO

Beneficiary Attribution

- If a beneficiary was already attributed by CMS to a Medicare ACO that becomes an D-ACO, that attribution holds unless the beneficiary affirmatively chooses another D-ACO
- All other qualifying beneficiaries are enrolled prospectively by DHMH, as follows:
  - Choose a PCMH attached to a particular D-ACO
  - Offered a choice of D-ACOs in which to enroll voluntarily
  - Auto-enrolled in a D-ACO for Medicaid purposes based on geography or needs
- Once attributed to a D-ACO by Medicaid, the beneficiary is attributed to the corresponding ACO by Medicare
- Prospective attribution to a D-ACO may be adjusted to reflect beneficiary's actual usage of care over time

DUALS ACO

Duals ACO Responsibilities

- Assist PCMHs with performance of PCMH functions
- Coordinate care for dual eligibles spanning acute care, behavioral care & LTSS as well as linking to social services
  - Duals ACO network must include all types of providers
- Receive and analyze data on attributed beneficiaries
- Report to providers and DHMH/CMS on activities and outcomes of care
  - Interconnection via CRISP required to enable both of above
- Bear a share of financial risk for beneficiaries' total cost of care
- Implement an internal incentive scheme for distribution of risks/rewards amongst D-ACO providers

DUALS ACO

Quality Measurement

- Quality measures tailored to dual eligibles (potential measures could be taken from the table on next page)
- D-ACOs are expected to meet quality measure performance benchmarks (e.g. 70% or higher scores on 80% of measures)
- Quality performance is factored into incentive award calculation

DUALS ACO

Quality of Care Measures – Dual Eligibles (Preliminary List)		
NQF #	**Measure Title**	**Measure Steward**
0004	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment*	NCQA
0006	CAHPS Health Plan v 4.0 – Adult questionnaire	AHRQ
0018	Controlling High Blood Pressure*	NCQA
0022	Use of High-risk Medications in the Elderly	NCQA
0032	Cervical Cancer Screening	NCQA
0101	Falls: Screening, risk-Assessment, and Plan of Care to Prevent Future Falls	NCQA
0104	Adult Major Depression Disorder (MDD); Suicide Risk Assessment	American Medical Association – Physician Consortium for Performance Improvement
0105	Antidepressant Medication Management*	NCQA
0201	Pressure Ulcer Prevalence (Hospital Acquired)	NCQA
0418	Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan*	CMS
0421	Adult Weight Screening and Follow-up	CMS
0553	Care for Older Adults (COA) – Medication Review	NCQA
0554	Medication Reconciliation Post-Discharge	NCQA
0576	Follow-Up After Hospitalization for Mental Illness	NCQA
0648	Timely Transmission of Transition record (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)	American Medical Association – Physician Consortium for Performance Improvement
1768	Plan All-Cause Readmissions*	NCQA
2380	Rehospitalization During the First 30 Days of Home Health	CMS
2456	Medication Reconciliation Number of Unintentional Medication Discrepancies per Patient	Brigham and Women's Hospital
2502	All-Cause Unplanned Readmission Measure for 30 Days Post Discharge from Inpatient Rehabilitation Facilities (IRFs)	CMS
2505	Emergency Department Use Without Hospital Readmission During the First 30 Days of Home Health	CMS
2510	Skilled Nursing Facility 30-Day All-Cause Readmission Measure (SNFRM)	CMS
2512	All-Cause Unplanned Readmission Measure for 30-Days Post Discharge from Long-Term Care Hospitals (LTCHs)	CMS
2597	Substance Use Screening and Intervention Composite	American Society of Addiction Medicine
2599	Alcohol Screening and Follow-Up for People with Serious Mental Illness	NCQA
2600	Tobacco Use Screening and Follow-Up for People with Serious Mental Illness or Alcohol or Other Drug Dependence	NCQA
2601	Body Mass Index Screening and Follow-Up for People with Serious Mental Illness	NCQA
2602	Controlling High Blood Pressure for People with Serious Mental Illness	NCQA
2603	Diabetes Care for People with Serious Mental Illness Hemoglobin A1c (HbA1c) Testing	NCQA
2604	Diabetes Care for People with Serious Mental Illness: Medical Attention for Nephropathy	NCQA
2605	Follow-Up after Discharge from the Emergency Department for Mental Health or Alcohol or Other Drug Dependence	NCQA
2606	Diabetes Care for People Serious Mental Illness: Blood Pressure Control (<140/90 mm Hg)	NCQA
2607	Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	NCQA
2608	Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Control (<8.0%)	NCQA
2609	Diabetes Care for People with Serious Mental Illness: Eye Exam	NCQA

NQF: National Quality Forum NCQA: National Committee on Quality Assurance AHRQ: Agency for Healthcare Research & Quality

DUALS ACO

Care Coordination Fee

- D-ACO receives an up-front care management fee (PBPM) from DHMH to help cover administrative costs of care coordination/case management
  - Determined based on beneficiary assignment
  - Varied based on beneficiary need level

Provider Payment

- All provider payment is regular Medicare/Medicaid fee-for-service

Spending Target Established for Incentive/Risk Purposes

- Upon beneficiary's attribution to a D-ACO, CMS and DHMH allocate a TCOC PBPM target amount to a pool associated with that D-ACO

DUALS ACO

Risk Sharing

- Initially, D-ACOs are not at risk for net deficits; this will change over time
  - Downside risk will be phased in starting Year 2
  - Risk/Reward formula will be skewed more to incentive bonus than to penalty
- At end of performance year, Medicare and Medicaid payments are summed and compared to TCOC benchmark
  - Aggregate of care coordination fees paid to D-ACO is added to health costs
- D-ACO deemed eligible for award if surplus *and* quality threshold reached
  - Reduced/No award if deficit or if D-ACO failed to hit minimum quality score
  - Government may recoup share of loss
- D-ACO is expected to distribute a meaningful portion of any award (or loss share) to network providers – of all types – that contributed to result
  - Internal risk/incentive plan is reviewed by DHMH, not prescribed
  - D-ACO may retain some of award to offset operational expenses not otherwise covered by the care coordination fee

DUALS ACO

Risk Sharing and Risk Mitigation

- Pro-rata sharing between Maryland and D-ACO
- Greater reward opportunity than risk of loss
- Risk mitigation caps amount ACO may lose
- Derived from MSSP Track 2 model

Illustrative Example of Reward/Risk Arrangement

	Year 1	Year 2	Year 3
ACO's Share of Savings	50%	60%	60%
ACO's Share of Losses	0%	40%	40%
Shared Savings Cap As Percentage of Total Cost of Care Target	10%	15%	15%
Shared Losses Cap As Percentage of Total Cost of Care Target	NA	7.5%	10%

CMS CHALLENGES WITH DUALS ACO VISION

- Restricting ACO choice may be viewed as restricting freedom of choice
  - Resolved by underlying provider network
- D-ACO differences with MSSP
  - D-ACO is unique, not MSSP; can be aligned with MSSP
  - National versus duals-appropriate quality measurement
- Alignment of D-ACOs and MSSP; possible solutions –
  - Begin with different models operating side-by-side
  - Possibility of "back room" administrative alignment through data reconciliation
  - Possibility of eventual total alignment, requiring MSSP-side change
  - D-ACO use of Track 2 risk sharing makes financial alignment possible

DUALS CAPITATED HEALTH PLANS

CMS

CMS Administrative Alignment Partnership

DHMH

One Plan Sponsor

MA D-SNP

Capitation Payment for:
Medicare Part C and Part D
Physician Services
Inpatient Hospital Services
Outpatient Pharmacy

Medicaid D-MCO

Capitation Payment for:
Nursing Facility Services
HCBS Services
Outpatient Services
Personal Care Services

Hospital Contracts: HSCRC Rate, Plus Upside/Downside Risk or Sub-capitation

ACOs under Contract: Capitation or Fee-for-Service Rates Plus Upside/Downside Risk

Health Home Contracts: PMPM for Case Management and Physician Services

DUALS CAPITATED HEALTH PLANS

- Capitated program including Medicaid and Medicare services for duals through integration with Medicare Advantage Duals SNP (MA D-SNP)
  - DHMH requires D-MCO sponsor to have MA D-SNP contract
  - Established care delivery entities and coordinators continue to function, though are contracted to health plans
- Interdisciplinary Care Team (ICT) can be utilized to integrate and coordinate care between Medicare and Medicaid services
  - Demo authority could allow state to require Medicare FFS PCPs to participate in ICTs if/when beneficiary opts out of MA D-SNP
- Health plan gets separate Medicaid and Medicare capitation payments
  - MA D-SNP plans may process an integrated set of claims rather than segregate Medicare from Medicaid payments
- Simplification of beneficiary-facing processes and compliance with Medicare Advantage requirements will occur through:
  - Administrative alignment between state and CMS requirements, processes
  - Cooperative oversight of plans

DUALS CAPITATED HEALTH PLANS

Beneficiary Enrollment

- Eligible beneficiaries include all full duals except I/DD
- For Medicaid, beneficiary is mandated to enroll in D-MCO plan
- For Medicare, beneficiary is passively enrolled or enrolls voluntarily in same sponsor's companion MA D-SNP plan
  - Greater odds of MA D-SNP take-up if CMS allows for passive enrollment with opt-out
  - If beneficiary opts out for Medicare coverage, program operates as Medicaid-only MCO
    - To aid integration, using demo authority, DHMH can work with CMS to develop information sharing agreements between Medicaid D-MCOs and Medicare FFS providers
- Enrollment will occur through an integrated process

DUALS CAPITATED HEALTH PLANS

Beneficiary Protections

- Plan monitoring will be aligned with Medicare Advantage and state requirements
- Participating plans must demonstrate an adequate network through:
  - Completion of the Medicare Advantage network review process
  - Compliance with Maryland network requirements for LTSS and other Medicaid services
- No additional beneficiary cost sharing
- Provide continuous beneficiary access to all medically necessary Medicare- and Medicaid-covered items and services
- Integrated appeals and grievances processes

DUALS CAPITATED HEALTH PLANS

Cooperative Oversight

A CMS-State Contract Management Team will be established to:

- Ensure access, quality, program integrity, financial solvency, compliance with applicable laws, and coordination of benefits
- Review and approve marketing and enrollment materials
- Review reports on beneficiary complaints, plan compliance, networking adequacy, and quality of care
- Receive input from stakeholders and ombudsmen on both plan-specific and systematic performance
- Respond to and initiate action on plan-specific and systematic performance issues

DUALS CAPITATED HEALTH PLANS

Appeals and Grievances

- Maryland will use a new simplified, integrated model notice for appeals explanations
- Integrated appeals processing:
  - Enrollees, their authorized representatives, and providers for Medicare service appeals will have 90 days to file an appeal related to denial, reduction, or termination of authorized Medicare benefit coverage
  - Enrollees, their providers, or their authorized representatives will have 90 days to file an MCO/SNP appeal related to the denial of services or payment or the reduction or termination of previously authorized Medicaid or Medicare/Medicaid hybrid benefit coverage
  - The 90-day period extends the typical Medicare period by 30 days to allow for additional flexibility for beneficiaries and to align the Medicaid and Medicare timelines
- Otherwise, Medicare Advantage appeals and grievances rules apply

DUALS CAPITATED HEALTH PLANS

Quality Measurement

Plans will be subject to measurement under

- Prevailing Medicare Advantage performance measures
- Additional, Maryland-specific, dual-tailored quality measures

COMPARISON OF DUALS STRAW MODELS

Model	Advantages	Disadvantages
Managed Fee-for-Service	• Easiest for State to start up • No investment required of providers for network formation • Most flexibility for beneficiaries • Very compatible with all-payer model	• Doesn't give providers greater accountability for TCOC and quality • Limited evidence of return on investment
Duals ACO	• Introduces care integration and accountability for TCOC and quality • More palatable to providers and consumers than managed care • Potential MACRA benefits for physicians* • CMMI interested: novel model in FFS	• Uncertain if today's ACOs/providers ready to step up, especially to take risk • Mechanical challenges: beneficiary attribution; measuring cost and quality, especially in LTSS • Potential all-payer model conflict
Capitated Health Plans for Duals	• Fully shifts risk for cost, plus quality accountability, to licensed entities, giving taxpayers budget predictability and possible savings • Known design with existing provisions	• Without Medicare enrollment mandate, low likelihood of sustainable participation • Most confining to beneficiaries • Little CMMI interest: not truly novel, not FFS

♦ CMMI: CMS's Center for Medicare and Medicaid Innovation ♦ TCOC: Total cost of care (per capita cost of all covered services)

* MACRA, the Medicare reform law that alters physician payments to reward physicians for engaging in value-based payment arrangements

DISCUSSION QUESTIONS

Care Coordination Entity

- Statewide or regional; how many regions?

Potential Transition from MFFS to D-ACO

- Would MFFS-D continue indefinitely in areas where no D-ACOs arise?
- Should CCE phase over to become facilitator/evaluator of D-ACOs?

Technical Implementation

- Provider community capacity to form/operate PCMHs and D-ACOs?
- MMIS/Medicare data capabilities to identify and track affected duals?
- IMPACT Act of 2014 implications?

MACRA Issues

- Does PCMH qualify physicians for advanced payment models (APMs)?
- How much downside risk is required for D-ACO to qualify for APMs?